

The United States Life Insurance Company in the City of New York  
New York, New York

Administrative Office: Client Services 3-A, 3600 Route 66, P.O. Box 1583, Neptune, NJ 07754-1583  
Phone: 1-800-346-7692 Fax: 1-732-922-7604

**EMPLOYER'S NAME:** \_\_\_\_\_

**EMPLOYER'S ADDRESS:** \_\_\_\_\_

**GROUP POLICY NO.:** \_\_\_\_\_

	Name	DOB	Social Security #
<input type="checkbox"/> Employee	_____	_____	_____
<input type="checkbox"/> Spouse	_____	_____	_____
<input type="checkbox"/> Dependent Child	_____	_____	_____

**QUALIFYING EVENT:**

Date Employment Ended: \_\_\_\_\_  
MONTH/DAY/YEAR

Date Employee Elected Medicare Primary: \_\_\_\_\_  
MONTH/DAY/YEAR

Date Employee Died: \_\_\_\_\_  
MONTH/DAY/YEAR

Date of Divorce: \_\_\_\_\_  
MONTH/DAY/YEAR

Date Child Ceases To Be Eligible: \_\_\_\_\_  
MONTH/DAY/YEAR

**1. ELECTION/REFUSAL**

**A) To be completed by the employee:**

- |   |  |
|---|--|
| <input type="checkbox"/> I wish to continue my employee health insurance;       | <input type="checkbox"/> I do not wish to continue my employee health insurance.       |
| <input type="checkbox"/> I wish to continue health insurance for my spouse;     | <input type="checkbox"/> I do not wish to continue health insurance for my spouse.     |
| <input type="checkbox"/> I wish to continue health insurance for my child(ren); | <input type="checkbox"/> I do not wish to continue health insurance for my child(ren). |

**B) To be completed by spouse/dependent child.**

- |   |   |
|---|---|
| <b>SPOUSE:</b> <input type="checkbox"/> I wish to continue my health insurance; | <input type="checkbox"/> I do not wish to continue my health insurance. |
| <b>CHILD:</b> <input type="checkbox"/> I wish to continue my health insurance;  | <input type="checkbox"/> I do not wish to continue my health insurance. |

**Note: If you elect to continue insurance, you must complete the INSURANCE TO BE CONTINUED section below.**

**2. INSURANCE TO BE CONTINUED:**

You may elect any combination shown below, but you can only continue insurance that was previously in force.

- |                       |   |   |  |   |
|-----------------------|---|---|--|---|
| Employee:             | <input type="checkbox"/> Major Medical Benefits | <input type="checkbox"/> Prescribed Drug Benefits | <input type="checkbox"/> Dental Benefits | <input type="checkbox"/> Vision Care Benefits |
| Spouse:               | <input type="checkbox"/> Major Medical Benefits | <input type="checkbox"/> Prescribed Drug Benefits | <input type="checkbox"/> Dental Benefits | <input type="checkbox"/> Vision Care Benefits |
| Dependent Child(ren): | <input type="checkbox"/> Major Medical Benefits | <input type="checkbox"/> Prescribed Drug Benefits | <input type="checkbox"/> Dental Benefits | <input type="checkbox"/> Vision Care Benefits |

**3. ACKNOWLEDGEMENT/SIGNATURE**

- I acknowledge that I have received and read the attached notice that explains the COBRA rights of continuation.
- I understand that if I elect to continue insurance, the payment of premium for it is my sole responsibility. I further understand that if premium is not received within 31 days of my premium due date, my insurance will automatically end as of the last day of the period for which premium was paid.

\_\_\_\_\_  
EMPLOYEE SIGNATURE DATE SIGNED

\_\_\_\_\_  
CHILD SIGNATURE (FOR CHILD AGE 18 OR OVER)\* DATE SIGNED  
\*EMPLOYEE SHOULD SIGN FOR A MINOR CHILD

\_\_\_\_\_  
SPOUSE SIGNATURE DATE SIGNED